COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

http://www.dmas.virginia.gov

NURSING FACILITY

(Includes Mental Health, Mental Retardation, and Specialized Care Services)
ENROLLMENT PACKAGE

Contents:

- Nursing Facility Enrollment Request Letter
- Nursing Facility Enrollment Instructions
- Nursing Facility Enrollment Application
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- Electronic Funds Transfer Application
- Provider Service Center Authorization Form

First Health Services Corporation
A Coventry Health Care Company
Fiscal Agent for Virginia's Medical Assistance Program – Provider Enrollment Unit

First Health Services Corporation
Provider Enrollment Unit
PO Box 26803
Richmond, VA 23261-6803
804-270-7027 (Fax)

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Thank you for your request to participate in the Commonwealth of Virginia's Medical Assistance Program. Requesting to become a provider does not constitute automatic acceptance into the Program. Upon receipt of your completed Enrollment Application, processing of the enrollment may take up to 15 business days. First Health is unable to accept altered agreements or agreements without a signature. Additionally, the application will be returned if any portion is filled out incorrectly and/or missing information.

Enclosed is the Virginia Department of Medical Assistance Services, Provider Enrollment Application. This application is required for initial enrollment in any of the Virginia Medical Assistance. A completed Enrollment Application must include the Enrollment Application, Address Form, Participation Agreement, and any required licensure documents.

All facilities must contact the Virginia Department of Health (VDH) at 804-367-2100 initially for authorization. All facilities must contact Clifton Gunderson P.L.L.C. at 804-270-2200 to establish the reimbursement rate(s). Skilled Nursing facilities must submit a copy of their current Medicare Certification as a Skilled Nursing Facility with the Enrollment Application. Institutions for Mental Diseases (IMD) must submit a copy of their Psychiatric Facility Accreditation from JCAHO and DMHMRSAS licensure with the Enrollment Application.

National Provider Identifier (NPI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique health identifier for health care providers. The NPI is the single provider identifier, replacing the different provider identifiers you previously used for each health plan with which you do business. The Final Rule for the NPI requires a "covered entity" Health Care Provider to obtain an NPI. HIPAA defined a covered entity as a Health Care Provider, Clearinghouse, or Health Plan that conducts standard electronic transactions. The transactions include claims, eligibility inquiries and responses, referrals, and remittance advices. Health Plans, including Medicare and Medicaid, must accept and use NPIs in standard transactions.

To participate as a provider of medical or health services for Virginia's Medical Assistance Program, you are required to obtain an NPI. DMAS has adopted the NPI as the standard for identifying all providers on all transactions, including paper claims. Therefore, you are required to obtain an NPI to participate in Medicaid and other DMAS programs even if you do not use electronic transactions

The Centers for Medicare and Medicaid Services (CMS) has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. As an individual Health Care Provider, you may apply for your NPI in one of two ways:

- You may apply through an easy web-based application process. The web address is https://nppes.cms.hhs.gov.
- You may prepare a paper application and send it to the entity that assigns the NPI. To obtain a National Provider Identifier (NPI) Application / Update Form (CMS-10114), contact the NPI Enumerator at 1-800-465-3203 or TTY 1-800-692-2326.

Please note that while an NPI may be associated with multiple service locations, DMAS is requiring the following set of primary information to be unique for an NPI:

- Provider Name
- Mail-To Address
- Pay-To Address
- Remittance Advice Address

- EFT Account Number
- EIN/SSN for Tax/1099 purposes
- Service Center/Receiver for electronic transactions sent to you by Virginia Medicaid

Out-of-State Enrollment in Virginia Medical Assistance Programs

A provider must be located within 50 miles of Virginia's border to be enrolled as an in-state provider. When a provider not within the 50-mile radius renders services to recipients, the provider can request enrollment for the date(s) of service only. To be reactivated in any of the Virginia Medical Assistance Programs, out-of-state providers must submit claims for services rendered and a letter requesting reinstatement to the Provider Enrollment Unit.

First Health Services Corporation (FHSC), fiscal agent for Virginia's Medical Assistance Program, administers all provider enrollment functions for Virginia Medicaid. First Health's Provider Enrollment Unit is available during the hours of 8:00 A.M. and 5:00 P.M. EST, Monday through Friday, to answer any enrollment questions you may have.

You may contact a Provider Enrollment Representative by calling:

1-888-829-5373 (In-state Toll Free)
OR
804-270-5105

Electronic copies of all Virginia Medicaid enrollment forms can be found at the Virginia Department of Medical Assistance Services website at (www.dmas.virginia.gov). **All applicants should visit the Virginia Department of Medical Assistance Services website and review the Nursing Facility Manual for their specific provider participation requirements.** Completed Enrollment Applications should be mailed or faxed to First Health's Provider Enrollment Unit at the following address or fax number:

First Health Services Corporation
Provider Enrollment Unit
PO Box 26803
Richmond, VA 23261-6803

804-270-7027 (Fax)

First Health Services Corporation
A Coventry Health Care Company

ENROLLMENT FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

1. National Provider Identifier (NPI)

Enter your 10-digit NPI as assigned by the National Plan and Provider Enumeration System (NPPES). If you are a business, enter your Organization (Type 2) NPI. If you are an individual, enter your individual (Type 1) NPI.

2. Legal Business Name.

The name of the business as registered with the Internal Revenue Service. If you have entered an Organization (Type 2) NPI in field #1, you must enter a business name. This name is used to generate and report 1099 information each year. A provider doing business under his/her own name should leave this section blank.

Individual Provider Name.

Individual providers are enrolled under the last name, first name, middle initial and professional title (e.g., M.D.). If you have entered an individual (Type 1) NPI in field #1, you must enter an individual name. This name is used to generate claim payments and report 1099 information.

3. Social Security Number

The Social Security Number (SSN) of the individual provider if the provider is not personally incorporated under an Employee Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code. For identification purposes, you must furnish your social security number. Additionally, Sections 1124(a)(1) and 1124A of the Social Security Act require that you disclose your social security number to receive payment.

OR

4. Employer Tax ID Number

Enter your Employer Identification Number (EIN). This is mandatory per Section 610g(a) of the Internal Revenue Code unless you are a member of a group that bills for services you render under the group NPI, or you are individually incorporated.

5. IRS Name

Enter your IRS Name as it is registered with the IRS.

6. Fiscal Year End

The month in which your fiscal year ends and the effective dates of the fiscal year. If there is not an End Date, leave this section blank.

7. Provider Program

The Virginia Medical Assistance Program(s) for which you are requesting enrollment. Note: Medallion II is the Virginia Medicaid Health Maintenance Organization (HMO) program.

8. Requested Effective Date of Enrollment

Enter the date that you are requesting your enrollment to begin.

9. License/Certification Number

The license number stated on your medical license from the **Virginia Department of Health Professions**. **Out-of-state providers must attach a legible copy of their licensure to the completed Enrollment Application.** If you have multiple licenses to report, please attach a separate sheet.

10. Specialty Codes

The primary specialty is first. Enter the date you were certified for your specialty. If you are certified in more than two specialties attach an additional sheet indicating the specialty and the effective dates. If you are a physician and you have a specialty, but do not include it on your Medicaid application, you will not be reimbursed for services that require a specialty certification for payment.

11. FDA Mammography Certification.

Enter your FDA Mammography Certification number. Enter the original issuance and expiration dates. You must include a legible copy of your FDA Mammography Certification with this application.

12. CLIA Number (Laboratory Services)

To be in compliance with the Center for Medicare and Medicaid Services (CMS) Clinical Laboratory Improvement Amendments (CLIA) of 1998, all laboratory testing sites must have a CLIA certificate of waiver or certificate of registration to legally perform laboratory services rendered on or after September, 1992. If you perform laboratory services, attach a copy of the CLIA certificate of waiver or certificate of registration.

13. Type of Applicant

Indicate the Type of Applicant: Individual, Limited Liability Partner, Sole Proprietorship, Corporation Partnership, Group Practice, or Hospital Based Physicians Health Maintenance Organization.

14. Facility Rating

Indicate whether the Facility is Profit, Non-Profit, or Not Applicable.

15. Facility Control

Indicate the Facility Control: State, Private, Public, City, Charity, or Not Applicable.

16. Number of Beds

If you are an institution, enter the number of beds for each type.

17. Administrator's Name

The name of the administrator of your practice or facility.

Remarks

Enter any additional information or comments in the Remarks section of pages 1, 2 or both.

ALL FORMS MUST BE SIGNED AND DATED

First Health Services Corporation
A Coventry Health Care Company

ADDRESS FORM INSTRUCTIONS

GENERAL INSTRUCTIONS

The Address Form allows providers to indicate their Servicing Address and where they would like to receive Department of Medical Assistance Services correspondence, payments, and remittance advice. If publications are to be sent to a billing agent, business office or any address other than the Servicing Address, the provider is responsible for obtaining the information for review and abiding by the regulations set forth in the publications.

- Provider manuals, manual updates, and memoranda may be accessed via the Department of Medical Assistance Services website at www.dmas.virginia.gov.
- The EDI Manual and updates may be accessed via the First Health Services EDI website at http://virginia.fhsc.com.

1. Servicing Address (Mandatory)

Indicate the physical location (street address) of where the provider renders services. Post office box addresses are not acceptable. Your Enrollment Application will be returned if submitted with a post office box address in this section. Enter your Primary Servicing Address in the Primary Servicing Address block on the Address Form. If you have more that one servicing location, use the Additional Servicing Address Form, page 9 of the Application, to enter additional servicing locations. Make additional copies of page 9 as needed

Note: For providers who are members of a Group Practice, enter the servicing address at which you practice and the Group Organization (Type 2) NPI of the billing group that bills for your services rendered at that address. If you provide services for more than one Group Practice, enter your servicing address for each and the Group Organization (Type 2) NPI that is associated with each servicing address.

2. Correspondence Address (Mandatory)

Indicate the address to which you would like Department of Medical Assistance Services correspondence (manual updates, memoranda, etc.) sent. A post office box address is acceptable***. Only one Correspondence Address is allowed per NPI. If there are multiple Correspondence addresses for your NPI, please choose one Correspondence address as the primary address for receiving Correspondence from the*** Department of Medical Assistance Services.

3. Pay-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services payments for services rendered sent. A post office box address is acceptable. If this section is left blank, payments will be sent to the Remittance-To Address. If there is no entry in the Remittance-To address section, payments will be sent to the ***Primary*** Servicing Address. ***Only one Pay-To Address is allowed per NPI. If there are multiple Pay-to addresses for your NPI, please choose one Pay-to address as the primary address for receiving Payments from the*** Department of Medical Assistance Services.

4. Remittance-To Address (Optional)

Indicate the address to which you would like Department of Medical Assistance Services Remittance Advice sent. A post office box address is acceptable. If this section is left blank, the Remittance Advice will be sent to the Pay-To Address. If there is no entry in the Pay-To Address section, the Remittance Advice will be sent to the Correspondence Address. If there is no entry in the Correspondence Address section, the Remittance Advice will be sent to the ***Primary*** Servicing Address. ***Only one Remittance-To Address is allowed per NPI. If there are multiple Remittance addresses for your NPI, please choose one Remittance address as the primary address for receiving Remittances from the*** Department of Medical Assistance Services.

For First Health's Use Only

Tracking Number_____

Provider Type _____

VIRGINIA MEDICAL ASSISTANCE PROGRAM PROVIDER ENROLLMENT APPLICATION

All applicants must fill out the Enrollment Application. The attached instructions contain the details that apply to each type of provider. A signed provider Participation Agreement is also required and must be submitted with each enrollment application.

THIS FORM IS TO BE USED FOR INITIAL AND ADDITIONAL ENROLLMENTS ONLY

1. NATIONAL PROVIDER IDENTIFIER _____

2. LEGAL BUSINESS NAME: _____
(If applicable, as registered with the Internal Revenue Service)

OR

INDIVIDUAL NAME: _____ **SUFFIX** _____ **TITLE** _____
(Name of the provider who performs the service)

3. SOCIAL SECURITY NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

4. EMPLOYER TAX ID NUMBER _____ **EFFECTIVE DATE** _____ **END DATE** _____

5. IRS NAME _____

6. FISCAL YEAR END

Month _____ **Begin Date** _____ **End Date** _____

7. PROVIDER PROGRAM: ___ **Medicaid** ___ **Medallion** ___ **Medallion II** ___ **State and Local Hospital (SLH)**

___ **Client Medical Management (CMM)**

___ **Temporary Detention Order (TDO)**

___ **Family Access to Medical Insurance Security Plan (FAMIS)**

8. REQUESTED EFFECTIVE DATE OF ENROLLMENT _____

REMARKS:
_____

_____

_____

_____

9. LICENSE/CERTIFICATION NUMBER _____ **LICENSING BOARD** _____

ISSUING STATE AND ENTITY _____

10. PRIMARY SPECIALTY _____ **LICENSING BOARD** _____

SECONDARY SPECIALTY _____ **LICENSING BOARD** _____

11. FDA MAMMOGRAPHY CERTIFICATION NUMBER _____

12. **CLIA NUMBER** _____

13. **TYPE OF APPLICANT (Please check one)**

___ **Individual** ___ **Corporation** ___ **Hospital Based Physician** ___ **Sole Proprietorship**

___ **Group Practice** ___ **Partnership** ___ **Health Maintenance Organization (HMO)**

___ **Limited Liability Partner**

14. FACILITY RATING (Please check one)

___ **Profit** ___ **Non-Profit** ___ **Not Applicable**

15. FACILITY CONTROL (Please check one)

___ **State** ___ **Private** ___ **Public**

___ **City** ___ **Charity** ___ **Not Applicable**

16. NUMBER OF BEDS

___ **NF** ___ **SNF-NF** ___ **SNF**

___ **Non-Cert** ___ **ICF-MR** ___ **Specialized Care**

17. ADMINISTRATOR'S NAME _____

REMARKS:

_____

_____

_____

_____

SIGNATURE _____ **DATE** _____

ADDRESS FORM

Use page 9 for additional servicing addresses

PROVIDER NAME _____ **NPI** _____

PRIMARY SERVICING ADDRESS (Physical location where provider renders services)

If you are a member of a group practice, enter the *group NPI* for this servicing address: _____

Attention _____

Address _____

Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail** _____

Contact Name _____ **Contact Phone** _____

CORRESPONDENCE ADDRESS (This address will be used to send forms, memoranda, etc.)

Attention _____

Address _____

Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail** _____

PAY TO ADDRESS

Attention _____

Address _____

Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail** _____

Contact Name _____ **Contact Phone** _____

REMITTANCE ADVICE ADDRESS

Attention _____

Address _____

Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail** _____

SIGNATURE _____ **DATE** _____

ADDITIONAL SERVICING ADDRESS FORM

PROVIDER NAME _____ NPI _____

ADDITIONAL SERVICING ADDRESS (Physical location where provider renders services)

If you are a member of a group practice, enter the *group NPI* for this servicing address: _____

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail** _____

Contact Name _____ **Contact Phone** _____

ADDITIONAL SERVICING ADDRESS (Physical location where provider renders services)

If you are a member of a group practice, enter the *group NPI* for this servicing address: _____

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail** _____

Contact Name _____ **Contact Phone** _____

ADDITIONAL SERVICING ADDRESS (Physical location where provider renders services)

If you are a member of a group practice, enter the *group NPI* for this servicing address: _____

Attention _____

Address _____
Street **Room/Suite** **City** **State** **Zip**

Office Phone _____ **Ext.** _____ **24 Hour Phone** _____

TDD Phone _____ **Fax Number** _____ **E-Mail** _____

Contact Name _____ **Contact Phone** _____

SIGNATURE _____ **DATE** _____

MAKE ADDITIONAL COPIES AS REQUIRED

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Medical Assistance Program

Nursing Home Participation Agreement

This is to certify:

Provider Name _____ ____ NPI _____

on this _____day of _____ , _____ agrees to participate in the Virginia Medical Assistance Program (VMAP), the Department of Medical Assistance Services, the legally designated State Agency for the administration of Medicaid.

☐	Initial, new applicant.	☐	Renewal/Re-certification	☐	Administrator change.	☐	State Owned
☐	Ownership change.	☐	Name change.	☐	Operator change.	☐	Community Owned

1. The provider is currently licensed and certified under applicable laws of this state and is not as a matter of state or federal law disqualified from participating in the Program.
   If appropriate, the provider has been fully certified by the Department of Medical Assistance Services to provide the service(s) checked below and assures that the service(s) are provided in accordance with laws, regulations, and policies governing the VMAP.

_____ Complex Care (for pediatrics only) _____ Rehabilitation Care (for pediatrics only) _____ Ventilator Dependent Care

2. Services will be provided without regard to age, sex, race, color, religion, national origin, or type of illness or condition. No handicapped individual shall, solely by reason of his medical or physical handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in accordance with the terms of Section 504 of the Rehabilitation Act of 1973 (29 U.S.C.§ 794) in VMAP.
3. The applicant agrees to keep such records as VMAP determines necessary. The applicant will furnish VMAP, on request, information regarding payments claimed for providing services under the state plan. Access to records and facilities by authorized VMAP representatives, the Attorney General, or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.
4. The provider agrees that charges submitted for services rendered will be based on the usual, customary, and reasonable concept and agrees that all requests for payment will comply in all respects with the policies of VMAP for the submission of claims.
5. Payment made by VMAP constitutes full payment except for patient pay amounts determined by VMAP, and the applicant agrees not to submit additional charges to the recipient for services covered under Medicaid. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Medicaid recipient for any service provided under Medicaid is expressly prohibited and may subject the provider to federal or state prosecution.
6. The applicant agrees to pursue all other available third party payment sources prior to submitting a claim to VMAP.
7. Payment by VMAP at its established rates for the services involved shall constitute full payment to the provider. Should an audit by authorized state or federal officials result in disallowance of amounts previously paid to the provider by VMAP, the provider will reimburse VMAP upon demand.
8. The provider agrees that when a patient is discharged to a hospital, the provider will assure that the patient be given an opportunity to be re-admitted to the facility at the time of the next available vacancy.
9. Should this agreement be terminated for any reason, it shall be the responsibility of VMAP to identify alternate sources of care.
10. In addition to its other obligations hereunder, the applicant agrees that it is responsible to care for its patients who are eligible for medical assistance to protect and maintain their health and safety, and to assist VMAP upon request in locating alternative sources of care for such patients. These obligations shall survive any cancellation, termination or expiration of this agreement until alternative sources of care are found for all such patients.
11. The provider agrees to comply with all applicable state and federal laws, as well as administrative policies and procedures of VMAP as from time to time amended. The provider agrees to comply with the regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including the protection of confidentiality and integrity of VMAP information.
12. Except as otherwise provided by applicable state or federal law, this agreement may be terminated at will on thirty days' written notice by either party. This agreement may be terminated by DMAS if DMAS determines that the provider poses a threat to the health, safety or welfare of any individual enrolled in any program administered by the Department.
13. Except as otherwise provided by applicable state or federal law, all disputes regarding provider reimbursement and/or termination of this agreement by VMAP for any reason shall be resolved through administrative proceedings conducted at the office of VMAP in Richmond, Virginia. These administrative proceedings and judicial review of such administrative proceedings shall be pursuant to the Virginia Administrative Process Act.
14. The provider agrees that DMAS may disclose the provider's NPI in directories and listings for dissemination to other health industry entities for purposes of using the NPIs for all purposes directly related to the administration of the State Plan for Medical Insurance.
15. This agreement shall commence on _____. Your continued participation in the Virginia Medicaid Program is contingent upon the timely renewal of your license. Failure to renew your license through your licensing authority shall result in the termination of your Medicaid Participation Agreement.

For First Health's use only

Original Signature of Administrator **Date**

Director, Division of Program Operations Date

First Health Services Corporation
A Coventry Health Care Company

MAILING SUSPENSION REQUEST

SIGNATURE WAIVER

PHARMACY POINT-OF-SALE

Please review and check the blocks, which pertain to you:

- q **MAILING SUSPENSION REQUEST:**
  I do not wish to receive Medicaid correspondence under the Medicaid provider number given below.
- q **SIGNATURE WAIVER:**
  I certify that I have authorized submission of claims to Virginia Medicaid, which contain my typed, computer generated, or stamped signature.
- q **PHARMACY POINT-OF-SALE AUTHORIZATION (in-state providers only):**
  I wish to submit Point-of-Sale billings to Virginia Medicaid.

I understand that I am responsible for the information presented on these invoices and that the information is true, accurate, and complete. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

PROVIDER NAME: _____

NPI: _____

SIGNATURE: _____

DATE: _____

TELEPHONE # _____

Please return the completed form to:

First Health Services Corporation
Provider Enrollment Unit
PO Box 26803
Richmond, VA 23261-6803

804-270-7027 (Fax)

First Health Services Corporation
A Coventry Health Care Company

ELECTRONIC FUNDS TRANSFER

Would you like your Medicaid and FAMIS checks to be automatically deposited in the account of your choice? If you want to participate in the Electronic Funds Transfer (EFT) program, just complete the enclosed form, tape a voided check to the form and mail or fax it to First Health at the address given below.

The start-up of EFT for a provider includes a two-week test period in which the banking institution and First Health tests the accuracy of the transfer of funds to a provider's bank account and the resolution of any detected errors. There is not a disruption in the routine disbursement of Medicaid claim payments as a paper check is generated with the provider's Remittance Advice during the test period. Upon completion of testing, the weekly deposit of funds takes place on the first business day after the Remittance date, which is typically a Monday.

The First Health Services, EFT Enrollment Representative will track the enrollment of all providers in EFT and will monitor the process each week to detect problems that may arise.

Please keep in mind the following when enrolling for EFT:

- Submit an **original** signature.
- Submit one form for each NPI or API as appropriate.
- **All** payments for each NPI or API must go to the same account.
- Processing time will be a minimum of 30 days from receipt of the completed form.

First Health Services Corporation
Provider Enrollment Unit
PO Box 26803
Richmond, VA 23261-6803

804-270-7027 (Fax)

First Health Services Corporation
A Coventry Health Care Company

Electronic Funds Transfer Application

GENERAL INFORMATION

_____
Provider Name

_____
Remittance Address City State Zip

Authorization Agreement for Automatic Deposits (CREDITS)

I hereby authorize FIRST HEALTH **and its subsidiaries to initiate credit entries, if necessary, debit entries and adjustments for any credit in error for the following Provider ID:**

NPI or API as appropriate	**Tax ID Number**

Printed Name **Title**

Signature **Date**

This authorization is to remain in full force until FIRST HEALTH **or the financial institution has received written notification from me and/or** FIRST HEALTH **of its cancellation in a timely manner so as to afford** FIRST HEALTH **and the financial institution a reasonable opportunity to act on it, or until the financial institution's cancellation of the agreement.**

☐ **Personal Account** ☐ **Business Account**

Place tape on this side ⟷

TAPE VOIDED CHECK HERE

First Health Services Corporation®
A Coventry Health Care Company

Provider Service Center Authorization

Please review and check the block(s) which pertain to you:

☐ **Electronic remittance request (835):**

I certify that I have authorized Service Center _____ to receive my electronic remittances (835) and that Service Center must have prior approval from First Health Services to receive such electronic remittances. I also understand that I will continue to receive paper remittances **only** for the time period selected below after the electronic remittances start. **(If no time frame is selected below, the default is 60 days.)**

☐ 30 days ☐ 60 days ☐ 90 days ☐ 120 days

☐ I understand that only one service center can accept and process my electronic remittances. In order to facilitate the above, I need to terminate Service Center _____ effective on _____ for my 835s.

☐ **Claims Status Request/Response (276/277):**

I certify that I have authorized Service Center _____ to submit Claims Status Requests and receive Claims Status Responses to the Department of Medical Assistance Services.

* IF YOU DO NOT QUALIFY FOR A NPI AND ARE REQUESTING A NEW API IN YOUR ENROLLMENT PACKET, LEAVE THE NPI/API NUMBER BLANK AND IT WILL BE FILLED IN BY PROVIDER ENROLLMENT AFTER THE API IS ASSIGNED.

PROVIDER NAME		NPI/API NUMBER
SIGNATURE	DATE	TELEPHONE NUMBER
PRINTED NAME		TITLE

Fax to: 1-804-273-6797, or
Mail Original to:
First Health Services Corporation
Electronic Media Claims Coordinator
Virginia Medicaid Operations
4300 Cox Road
Glen Allen, VA 23060
(800) 924-6741